

## Bayou Health Provider Call – Summary

February 11, 2015

FOLLOW-UP ASSIGNMENTS	
1. Pregnancy Application Processing	See follow up in Q&A below
2. Protocol for Erroneous Assignments	
3. MCO Eyewear Policies	
4. Protocol for Billing an Emergency claim for a non-participating Provider	
5. Prior Authorization Contact information with the MCOs	
6. Informational Bulletins pending for 39 week elective deliveries and provider communication	
7. Behavioral Health Informational Bulletin	

### **Meeting Facilitator:**

Mary TC Johnson, Deputy Medicaid Director

### **DHH Announcements**

- United Health has corrected the issue with OptumRx. Pharmacy providers now can utilize the Medicaid identification number or the OptumRx number to submit a claim.
- 39 Week Elective Delivery Initiative-A policy was issued indicating the physicians and hospitals are to no longer receive payment for births prior to 39 now weeks that are not medically necessary. Molina implemented this on the fee for service side on 9/1/2014. There were some successes and some slowdowns during this implementation. Implementation on the MCO side was delayed. It will begin on 3/1/2015. The process will be similar to the Blue Cross Blue Shield method. DHH still needs to work on the informational bulletin for this initiative as well as conduct provider communication. The goal is to work on these items this week.
- On 3/1/15 the new Magellan Behavioral Health contract will go into effect. Many of the processes will be the same but there has been significant simplification in how DHH streamlined the allocation of the responsible party for payment of claims. DHH has spelled out a list of whether specific providers submit claims to Magellan, Bayou Health or Molina. Effective 3/1/2015, the payor will depend on provider type rather than diagnosis code. All specialized or Licensed Mental Health Providers (LMHP) must contract through Magellan. As such, Magellan will be responsible for prior authorization and claims adjudication. For example, if a member is in a Bayou Health Plan and is taken to a general acute care hospital and placed in an acute care bed, all facility and non-specialized behavior health professional services should approved and adjudicated for payment through the Bayou Health Plan. Any consultation or services provided by a LMHP would be approved and adjudicated through Magellan. If the services are in a distinct part or independent Psych unit, they would be approved and processed through Magellan.

DHH is planning to conduct a conference call for behavioral health specialists in general. DHH will also have a Federally Qualified Health Center (FQHC) and a Rural Health Clinic (RHC) call to

discuss behavioral health with these providers. This conference call will not be scheduled until everyone has an opportunity to review the behavioral health bulletin that has not been published yet.

- TPL-A Uniform TPL form standardized for everyone's use is now online and available. The form contains a drop box for the entity to which the TPL information is being sent. The fax numbers are provided as well. The link to the website is:  
[http://www.lamedicaid.com/ProvWeb1/ProviderTraining/Packets/2008ProviderTrainingMaterials/Recipient\\_Insurance\\_Update.pdf](http://www.lamedicaid.com/ProvWeb1/ProviderTraining/Packets/2008ProviderTrainingMaterials/Recipient_Insurance_Update.pdf)
- PHI information should not be sent to the [bayouhealth@la.gov](mailto:bayouhealth@la.gov) address if you do not have the ability to send secure email. Information containing PHI can be sent via fax at 225-389-2750.

### **Questions & Comments**

*Q: How can I determine who the Provider Rep for Children's Hospital is with Aetna?*

*A: The provider gave her name and contact number to the CEO of Aetna who will contact her after the conference call to discuss her concerns.*

*Q: How can I determine who the Provider Rep is for submitting prior authorizations with Aetna?*

*A: Please send something to [bayouhealth@la.gov](mailto:bayouhealth@la.gov) and DHH will distribute the response.*

*After call follow-up: The Aetna Provider portal may also be utilized in some cases for Prior Authorizations [www.aetnabetterhealth.com/louisiana](http://www.aetnabetterhealth.com/louisiana) or call their main line at 1-855-242-0802.*

*Q: What is the status of the circumcision informational bulletin?*

*A: This has not been completed. DHH has verified that it is only for newborns but each health plan has nuances surrounding the time period for births prior to 2/1/15. It is based on any services after 2/1/2015. If the services were before the date of discharge it will be the responsibility of the health plan prior to 2/1/15.*

*Q: Have the procedure code updates been completed? We have outstanding denials prior to 2/1/15 that we can't get paid. Now that the new contracts are in place and the precert is closed, how do we update the claims in order for payment to occur?*

*A: For dates of service prior to 2/1/15 providers will continue to reconcile any adjustments or appeals through Molina.*

*Q: How do we reconcile any adjustments or appeals through Molina, now that the phone and fax numbers are turned off?*

*A: The codes cannot be added at this time. The provider will need to submit the claim for payment and it will pay since the edits are turned off.*

*Q: Does the MCO requirement that nonemergency transportation be prior authorized fall within DHH guidelines?*

*A: The MCOs can require PA for nonemergency transportation. It is within the purview of the health plans to require the PA.*

*Q: Is requiring 48 hour notification with DHH guidelines?*

*A: Yes. It is within their purview to require advance notice. They should have a methodology so that every trip for ongoing standing appointments (dialysis) does not require individual prior authorization, but can be authorized for a set time period. They can set the timeline of how far in advance the prior authorization must be requested.*

*Q: What are the changes for behavioral health effective 2/1/15?*

*A: There are no changes effective 2/1/15. Effective 3/1/15 DHH will no longer use diagnosis codes. We will look at provider type to determine who is responsible for the PA, claim, etc. Provider type will be used to decide if it goes to Bayou Health, Magellan or Molina. If you are a specialist or a distinct part psych unit or a stand-alone psych facility and you provide a service to a Medicaid member, then it will be sent to Magellan.*

*Q: What is an example of the type of claims that will not be billed to Magellan after 3/1/15?*

*A: Acute care hospitals in a regular bed when the primary diagnosis was between 299.xx and 319.xx. These will be paid by the Bayou Health Plan. Most emergency room services and acute care hospitals will be paid by the Bayou Health Plan. [After call follow up: The professional services by a Specialized or Licensed Mental Health Provider \(Psychiatrist, Licensed Psychologist, Social Worker, etc.\) would be approved and processed through Magellan.](#)*

*Q: Is there a behavioral health informational bulletin?*

*A: DHH is working on it.*

*Q: What about the psychologist in the emergency room that comes for a consult? Who will they bill?*

*A: We will get into those types of details in the informational bulletin that DHH is working on and during the behavioral health call next week when it is scheduled. [After call response: The professional services by a specialized \[After call follow up: The professional services by a Specialized or Licensed Mental Health Provider \\(Psychiatrist, Licensed Psychologist, Social Worker, etc.\\) would be approved and processed through Magellan.\]\(#\)](#)*

*Q: Is there an overall rule or regulation like CMS with Chapter 124 of the Managed Care guidelines that MCOs must follow? Commercial plans follow Louisiana administrative code; do the Bayou Health Plans have something to follow on facility appeals?*

*A: On the member appeals side there are CMS regulations about appeals. I don't think there is a provider appeal requirement in the federal registry but staff is not online to confirm that at this moment. [After call follow up: Federal Regulations do not require or provide for Provider appeal rights for service denials or claim denials. There are provider appeal requirements for provider sanctions. However, DHH contracts with the MCOs do require the MCOs to have a provider appeal process in place.](#)*

*Q: In Louisiana is there a rule that the MCOs have to follow?*

*A: There is information within the contracts with the MCOs that must be followed. Jode Burkett in DHH Provider Relations will follow-up with the provider after the call.*

*Q: Do they have observation rules?*

*A: DHH will post this response. [After Call Response: DHH has posted a Health Plan Advisory HPA 15-4: Authorization and Payment of Observation Status](#). Each health plan should include there individual policy and guidance in there provider manuals.*

*Q: United customer service reps are informing our patients that we are not in network. We were not informed that we were dropped. What is going on?*

*A: Prior to 2/1/15 the shared plans such as United Health used Medicaid's provider network. Now that United Health is a full risk MCO they are responsible for the entire network of providers. If you had a prior authorization with United Health, Molina, prepaid health plan or any shared health plan approved prior to 2/1/15 that MCO will need to respond to you as to what should be done for those prior authorizations when the provider is out of network. They should explain how to get paid and how to submit the information. United Healthcare agreed to contact this provider during the call.*

*Q: On the last call it was stated that it was most important that the TPL updates go to the MCOs, can you confirm if we are still required to put the TPL code on all of the claims we submit that have TPL?*

*A: For those claims that are fee for service, yes. If the provider is billing the MCO, it would be up to the individual MCO. You can send an email and I will forward your information to all 5 health plans.*

*Q: In a United Health town hall conversation that I attended, they stated to submit TPL information to DHH and not to them is this correct?*

*A: When United Health was a shared savings plan that was a correct statement. United Health care will reeducate their staff.*

*Q: For a while we have noted a lot of invalid policy numbers on the DHH website, I was told that it was a system error and they were working on it. LHC is denying claims do to these invalid policy numbers claiming that EOBs are needed to process the claims. LHC is telling me to send it to Medicaid and once updated their system will be updated. Is DHH aware of this issue?*

*A: LHC should be maintaining a TPL file. DHH is not aware of the issue. We were afraid that there would be issues with reducing some of the requirements we had for our files. Please send examples to Bill Perkins at the fax number given.*

*Q: The Health Plans have indicated that they will be covering circumcisions but we are getting mixed answers. ACLA informed us that they only cover one code. Does DHH have any clarifications regarding the MCO's circumcision policies?*

*A: DHH is looking at creating an informational bulletin on the MCOs basic circumcision policy as a value added benefit. Hopefully we can get something out by today or tomorrow as an informational bulletin.*

*Q: Aetna is stating that we have 90 days to submit a claim instead of 30 for continuity of care but we do not plan to be providers enrolled with Aetna, how will this affect us and how will we be paid?*

*A: DHH indicated in the contract that providers have 180 days to submit a claim. Providers will have to contact each health plan to find out what you have to do if you are an out of network provider. If it was already approved then Aetna will have to pay for the first 30 days and you will have to get with them as far as how you would submit your claims. For anything that is on the published fee schedule the provider has to pay the minimum unless the provider has alternate language within their contract. There is a DME fee schedule on the website.*

*Q: Patients assigned in error to the wrong plan and should have been assigned to LHC effective 2/1/15, who should they go to for correction?*

*A: We did have problems with erroneously auto assigned newborns. The assignment of the newborn will follow the mother unless otherwise requested. Please send the details to DHH to the attention of eligibility.*

*Q: Where do we send TPL information?*

*A: There is an online form with a drop down box. It is found at [www.lamedicaid.com](http://www.lamedicaid.com) and it is a fillable pdf form. When you select a recipient the fax number will be auto filled. It must be filled out online to get the drop down box.*

*Q: An OB provider saw a patient who did not have Medicaid in January, she was applying for Medicaid. She was treated as a new cash patient. When the patient returned for an ultra sound and prenatal visit, she was Medicaid eligible. The provider honored the Medicaid for February and billed the MCO accordingly. Amerigroup states that the doctor must refund the patient and submit the claim to Amerigroup. If a patient is not Medicaid eligible on the date of service, is the provider obligated to refund the patient and bill the MCO?*

*A: Bill Perkins suggested that DHH have an in house conversation on how the health plans should handle these situations.*

*Q: How will retro-enrollments work with the shortened timely filing timeframes?*

*A: DHH will go over this with the health plans.*

*Q: On the Aetna website there is a downloadable form for electronic payment processes, when we contacted customer services that were not aware of the electronic form and stated that Aetna does only do paper checks? While awaiting the electronic process should we anticipate paper checks?*

*A: Before EFT is up and running providers will receive paper checks and Aetna upper management will reach out to the manager of customer service and educate them on the EFT policy.*

*Q: If you are trying to get PA in current review from Aetna, what should be done?*

*A: Call 1-855-242-0282 and select provider option when prompted for appropriate clinical staff. We will see how this needs to be published through Aetna.*

*After call follow-up: The Aetna Provider portal may also be utilized in some cases for Prior Authorizations [www.aetnabetterhealth.com/louisiana](http://www.aetnabetterhealth.com/louisiana).*

*Q: Can you provide an overview of HPA 15-2?*

*A: This is the covered and non-covered services. We are coming out with an Informational Bulletin targeting providers to mirror some of this language. What DHH is trying to do is figure out what services are provided on a covered or non-covered day. We are asking hospitals to accept Molina's way of processing claims today. If a provider is approved to pay 5 days of inpatient care and you bill for 6, Molina will deny the whole claim. The hospital can appeal but Molina will always deny if the days do not match what was approved. Some of the MCOs were able to deny the 1 day but it messes DHH's cost reporting for the health plans so we are asking all the hospitals to accept Molina's way of billing and processing these claims. If you need the denial you can bill for the five and bill for the six days separately and that will give you the denial that you need.*

*After Call Follow Up – The Informational Bulletin that mirrors this HPA is IB 15-3.*

*Q: Will Bayou Health Plans accept split billing?*

*A: Yes. This is what we are asking them to do. This is effective 2/1/15*